CHAPTER 2
General adult psychiatry

Psychotic illness I

A. Acute and transient psychotic disorder
B. Bipolar affective disorder
C. Catatonic schizophrenia
D. Hebephrenic schizophrenia
E. Paranoid schizophrenia
F. Residual schizophrenia
G. Schizoaffective disorder
H. Schizotypal disorder
I. Simple schizophrenia
J. Undifferentiated schizophrenia

The following patients present with a psychotic episode. Select the most appropriate diagnosis from the above that best fits with the following clinical description.

1. An 18-year-old male is brought to hospital by his parents because they have noticed that he has been acting strangely recently. His parents say that the patient has just 'lost it' since failing his final examinations. The patient was noted to be giggling to himself, spending almost all his time in his room, and making unusual gestures with his hands. In addition, his speech has been incomprehensible and his parents cannot make any sense of it.

2. A 30-year-old female is brought to hospital as she has been violent and hostile to her neighbours. According to the patient, her grandfather was a successful writer and she acquired his fortunes recently. However, she believes that her neighbours have found out about it and claims that she has heard them talking about stealing her money.

3. A 37-year-old female who previously held a managerial position in a large financial firm is brought to hospital by her

parents. According to the parents, the patient has not been coping with her work for the last few years and has gradually become withdrawn. She was fired from her work 3 years ago and since then, has been doing nothing but smoking in her bed all day. On mental state examination, her affect is blunted and she appears to have no motivation.

4. A 25-year-old male is brought to hospital as he was found to be trashing his apartment and throwing things from his window. He claims that everything in his flat is 'contaminated' and that voices are instructing him to get rid of all his possessions. He admits that this has been going on for a week. He agrees to a urine drug test, and the results are negative for all drugs. A week after admission, however, he makes a dramatic recovery and is now completely back to normal.

5. A 27-year-old male with no previous psychiatric history is brought to hospital by his family. His parents noticed that he has been 'high' for the last few months, and that his behaviour has become increasingly erratic. He was also noted to have strange beliefs, such as the world being flat and the government trying to prevent this fact from being disclosed. He even stated that he has a radio-transmitting device implanted in his head which allowed him to pick up the signals sent from space. His elated mood and strange beliefs continued for a year.

Psychotic illness II

A. Acute and transient psychotic disorder
B. Bipolar affective disorder
C. Catatonic schizophrenia
D. Hebephrenic schizophrenia
E. Paranoid schizophrenia
F. Residual schizophrenia
G. Schizoaffective disorder
H. Schizotypal disorder
I. Simple schizophrenia
J. Undifferentiated schizophrenia

The following patients present with a psychotic episode. Select the most appropriate diagnosis from the above that best fits with the following clinical description.

1. A 38-year-old male was previously in a general psychiatric ward for 2 years because he thought that the government was sending beams into his brain and trying to control his actions. He is now discharged into the community and seems less bothered by those thoughts. However, he prefers to stay indoors and does nothing all day, hardly socialising with anyone. On approaching him, he shows marked poverty of speech and a restricted affect.

2. A 46-year-old female is brought to hospital as she believes that she is a divine being in the process of transforming into God. She believes that she is able to control other people's feelings and behaviours. In the last few days, she has become increasingly aggressive to her neighbours as she thinks that they are stopping her from acquiring further powers. On examination, her speech is normal and no signs of elation or agitation are seen. Her psychiatric history is unremarkable.

3. A 38-year-old male is described as a 'loner' by his family as he does not seem to have any close friends. He usually spends his time alone at home because he becomes extremely anxious around other people. When talking to others, he feels that they are being nice to his face but that there's an alternative agenda. He likes to dress in silver clothing because he feels it brings him 'closer to cosmic forces'.

4. A 25-year-old male is taken to hospital by the police as he was found screaming on the streets. He had been trying to light himself with a lighter, claiming that he was invincible and had the power to fix all evil in the world. His speech was highly pressured and he complains that his thoughts are going out of control. According to hospital records, he had been admitted to hospital three times in the last year for similar episodes.

5. A 30-year-old male is brought to hospital by his family because of increasing concerns about his behaviour. In the last few months, the patient has been going through periods when his mind appears to be preoccupied, staring in space and maintaining a funny posture like a statue. On examination, he is mute and does not respond to any stimuli. His urine drug screen is negative.

The anxious patient

A. Adjustment disorder
B. Agoraphobia
C. Conversion disorder
D. Generalised anxiety disorder
E. Hypochondriasis
F. Obsessive-compulsive disorder
G. Panic disorder
H. Post-traumatic stress disorder
I. Social phobia
J. Somatisation

The following patients present with symptoms of anxiety. Select the most appropriate diagnosis from the above that best fits with the following clinical descriptions.

1. A 20-year-old male becomes anxious in the company of unfamiliar people and fears possible scrutiny by others. He worries that he will act in a way that will be humiliating or embarrassing, and he attempts to avoid such situations. He realises that this has resulted in him failing to get promoted at work.

2. A 30-year-old female avoids travelling alone, using public transport, or being in crowded places as this makes her feel anxious. She feels that such situations make her feel unsafe. She eventually becomes housebound as she identifies her home as being the only safe place for her.

3. A 32-year-old male has recurrent and persistent thoughts of contamination, which he recognises are irrational. He washes his hands repeatedly throughout the day, which relieves his anxiety. He also performs a ritual which must be performed in the correct order in order to prevent something dreadful happening to his wife.

4. A 37-year-old female, who previously held a managerial position in a large financial firm, presents to the clinic saying that she is no longer able to continue with her job. About a month ago, she started having episodes of dizziness and palpitations, coupled with the thought that she was 'going to die'. These

episodes only last for a few minutes, and seem to occur randomly at home, work, or outside. Although she is able to function normally between these episodes, she is now worried as to when these attacks will next come on.

5. A 22-year-old male is preoccupied with the fear that he has cancer. He has had a number of investigations which have not revealed any abnormalities, but is not reassured. He has visited three hospitals in the last year.

The stressful patient

A. Abnormal grief reaction
B. Acute stress reaction
C. Adjustment disorder
D. Agoraphobia
E. Conversion disorder
F. Depressive disorder
G. Generalised anxiety disorder
H. Normal grief reaction
I. Post-traumatic stress disorder
J. Simple (specific) phobia

The following patients present with a reaction to stress. Select the most appropriate diagnosis from the above that best fits with the following clinical descriptions.

1. A 65-year-old male was admitted to a medical ward with a history of chest pain, low mood, and weight loss. No medical cause was found. He said that about 12 days ago, his house was burgled and he lost his belongings. He progressed well in the ward and appeared cheerful, but as his discharge date approached, he complained of feeling 'not right' and refused to go back home.

2. A 47-year-old female and her son were involved in a car accident while she was driving. Her son unfortunately died in the accident, and she spent 2 weeks in hospital for a head injury. Although she made an uneventful recovery, 4 months after the accident, she started experiencing intrusive thoughts about the accident. She has been unable to get into a car and has avoided visiting the accident site. She complains of poor concentration, anxiety, and low mood.

3. A 22-year-old college student found out that her previously well father was killed in a car accident unexpectedly. She returns home and prepares for her father's funeral, but finds it very difficult. She is tearful, agitated, and unable to concentrate. Two years later, she is still mourning her father's death and has dropped out of college. She has avoided visiting the site of the accident, and also seems to deny the incident. Her father's room is left untouched since the day of the accident, and she pretends that he is still alive.

4. A 24-year-old medical student travels abroad for his elective. While going back to his residence late at night, he is held to a gunpoint by two masked figures asking for his money. He promptly hands his wallet and the assailants run away. He returns home but upon arrival, he feels numb and becomes tearful. The following day, he has recollections of the events but is no longer troubled by it.

5. A 32-year-old female is unable to walk following her sudden separation from her husband. She is now unable to walk unaided and requires a wheelchair, and her husband had agreed to visit her once a week to help her out. Neurological examination is inconsistent with her symptoms and investigations are all normal.

The patient with unexplained symptoms

A. Dissociative amnesia
B. Dissociative motor disease
C. Dysmorphophobia
D. Factitious disorder
E. Ganser's syndrome
F. Hypochondriasis
G. Malingering
H. Schizophrenia
I. Somatisation disorder
J. Trance and possession disorder

Select the most appropriate diagnosis from the above that fits with the following clinical descriptions.

1. A 23-year-old female presents to hospital complaining of abdominal pain. She was admitted to the surgical ward, but was very demanding of the nurses' attention. She underwent several blood tests and a colonoscopy, all of which were unremarkable. Once her investigations were completed, she self-discharged. Her records indicated that this was her fifth admission in 5 months, each admission resulting in self-discharge.

2. A 23-year-old female presents to hospital complaining of abdominal pain. She was waiting calmly and smiling, but when seen by the doctor, she starts screaming that she is in pain and demands that she be treated with morphine to alleviate the pain. However, her history and physical examination were inconsistent and investigations, including an X-ray, were unremarkable. A member of staff recognises her from a few weeks ago when she gave a different alias and demanded for morphine. He suspects that she is a heroin addict.

3. A 23-year-old female presents to hospital complaining of abdominal pain. While waiting in the emergency department, the ward staff retrieves her records and finds that she has been presenting almost on a weekly basis for the last 15 months with problems such as abdominal pain, headache, and constipation. On contacting her general practitioner, he informs that the patient presents on a weekly basis to his practice with minor

problems such as itches, dizziness, and joint aches. He further informs that she has been having difficulties with her partner for the last 2 years following their arranged marriage.

4. A 23-year-old female presents to hospital complaining of abdominal pain. While waiting to be seen, she demands that she be referred to the surgical team for further investigations, as she is highly anxious that she has colon cancer. She is eventually admitted and undergoes a colonoscopy, which was unremarkable. Despite reassurance from the surgeons, she is convinced that she has colon cancer as she feels that the surgeons are trying to be nice and are hiding the 'horrible facts' from her.

5. A 23-year-old female presents to hospital complaining of abdominal pain. While waiting to be seen, she is noted to have heavy vaginal bleeding. She was referred to the gynaecologists, who find that she had 'retained products of conception' in her uterus. On questioning, she denied any pregnancy but her husband informs that she had a miscarriage the day before. Otherwise, the patient's cognition is intact with a score of 30/30 on the mini-mental state examination.

The patient with memory problems

A. Anterograde amnesia
B. Confabulation
C. Deja vu
D. Delusional memory
E. Delusional misidentification
F. Dissociative amnesia
G. Dissociative fugue
H. Jamais vu
I. Malingering
J. No mental illness

The following patients present with memory problems. Select the most appropriate item from the above that best matches the clinical description.

1. A 56-year-old male suffering from schizophrenia is discharged home as his mental state is now stable after a 4-week admission. On returning home with the social worker, however, he initially says that his house seemed unfamiliar, as if it was like a stranger's house, but he quickly recognises it as his own.

2. A 45-year-old male with a history of alcohol abuse is admitted to a ward. He was oriented to the ward but is unable to remember the name of the ward or hospital. He is also unable to remember the name of his primary nurse despite seeing her everyday. His psychiatrist comes and interviews him, but he repeatedly asks her name.

3. A 24-year-old female recently lost her fiancé in a car crash. Following this, she is reported missing by her family as they are unable to get hold of her, but police reports indicate that she was working in a bar abroad. Four weeks later, she returns home in a completely fit state but is unable to recall where she has been.

4. A 40-year-old female suffering from schizophrenia breaks down into tears during the ward round, saying that she was raped by her brothers during childhood. Collateral history from her mother indicates that she is the only child, but she remains

adamant that her brothers raped her. She points to stretch marks on her abdomen and says that they are proofs of the sexual assault.

5. A 43-year-old male had an argument with his wife, as he was not forthcoming about where he has been spending his time during the day. When the wife confronts him whether he was out gambling, he replies: 'Yes yes, I have been gambling … in fact I won quite a bit!' However, his explanations are unreliable and appear to change significantly during the conversation depending on what the wife says. He has a history of alcohol abuse.

Mood disorders I

A. Bipolar affective disorder
B. Cyclothymia
C. Depressive episode, mild
D. Depressive episode, moderate
E. Depressive episode, severe
F. Dysthymia
G. Hypermania
H. Hypomania
I. Mania
J. Recurrent depressive disorder

The following patients present with mood disturbances. Select the most appropriate diagnosis from the above that best fits with the given clinical descriptions.

1. A 28-year-old female presents to the clinic complaining of low mood. She explains that she has always felt low, as if something was missing from her heart. Other than that, she has no complaints, and her sleep and appetite are both healthy. She is able to keep her job and appears to be enjoying a reasonable social life.

2. A 28-year-old female presents to the clinic complaining of low mood. She has been feeling like this for the last 3 months and is unable to identify any triggers. She feels tearful and does not seem to enjoy things she once did. She is still able to go to work, although at times it has been difficult for her to concentrate. Her appetite has decreased but she manages to sleep around 7 hours per night. Her past psychiatric history is unremarkable.

3. A 28-year-old female presents to the clinic complaining of low mood. She describes her mood as 'depressing' and is unable to do anything. Because of her low mood, she has not eaten for 3 days. She mentions that a year ago, she was feeling on top of the world and went through periods when she did not have to sleep. On that occasion, she was admitted to hospital because her parents thought that she was going 'out of control'.

4. A 28-year-old female presents to the clinic, but she is overactive and unable to sit still. When she finally starts talking, she

is clearly over-excited and her thoughts are hard to follow. She vaguely mentions about having a special connection with God, and that she is the 'chosen one'. She believes that she has the power to heal all human suffering from the world, and even claims that she is hearing God's voice at present. Her past psychiatric history is unremarkable.

5. A 28-year-old female presents to the clinic, but the doctor is unable to fully carry out an assessment as the patient is mute and does not make any eye contact. According to the mother, the patient has been like this for the last few weeks and has hardly eaten anything. She has told her mother that she is 'dead' and thus does not need to be fed. Earlier today, she was found stacking a pile of wood in the garden as she wanted to cremate her dead body. Her past psychiatric history is unremarkable.

Mood disorders II

A. Atypical depression
B. Bonding failure
C. Childhood depression
D. Depression in the elderly
E. Dysthymia
F. Postpartum blues
G. Postpartum depression
H. Postpartum psychosis
I. Premenstrual syndrome
J. Seasonal affective disorder

Select the most appropriate diagnosis from the above for each of the following statements.

1. Depressive episode whereby the patient complains of depressed mood less often and instead complains of physical symptoms such as disturbed sleep and somatic problems. These patients remain at substantially higher risk of completed suicide.

2. Affective episode temporally related to childbirth with an abrupt onset at about 2–4 weeks. The episodes may be marked with psychotic features such as hallucinations and delusions relating to the baby. Risk is increased in first time mothers and instrumental deliveries.

3. Depressive episode in which the patient does complain of low mood, but appears to lack the biological and other associated features of depression. The patient can present with features such as hypersomnia, hyperphagia, and heaviness of limbs.

4. Clinical symptoms involve low mood, hypersomnia, fatigue, increased appetite, and weight gain. Social functioning can be decreased during the duration of the episode. The episodes follow a recurring pattern, and light therapy is a suggested form of treatment.

5. Depressive episode characterised by low mood, anhedonia, and altered sleep and appetite. In addition, it may manifest with somatisation, behavioural disruptions, and substance abuse. Male to female rate is roughly equal, and completed suicide is rare.

Personality disorders I

A. Anankastic
B. Anxious (avoidant)
C. Dependent
D. Dissocial
E. Emotionally unstable – borderline
F. Emotionally unstable – impulsive
G. Histrionic
H. Paranoid
I. Passive aggressive
J. Schizoid

Select the most appropriate diagnosis from the above that fits with the following clinical descriptions.

1. A 45-year-old male works in data processing from home. He has never had a relationship, and was often described as a loner at school. He hardly has any friends, but is not bothered by it as he prefers working and living at home alone.

2. A 30-year-old female works as a medical secretary. She always arrives to work 2 hours before everyone else as she likes to ensure that her desk and the office is in order. She usually leaves work 2 hours late as she has difficulty completing her work on time due to her thorough checking and rechecking. The other secretaries think she is stubborn and become annoyed with her when she insists that they do things in a similar way.

3. A 50-year-old female describes herself as 'always having mood swings'. She goes out on a blind date with a man she has met over the Internet, but while having a conversation about politics in a restaurant, she gets upset about a comment her date makes. She starts screaming at him and throws dishes on the floor, screaming: 'Look what you made me do.'

4. A 22-year-old bubbly female college student has a lot of friends, but they often complain that she has verbal diarrhoea and finds her to be too dominating in conversations. She often wears very short skirts and likes being the centre of attention. While out clubbing, she trips over and scratches her leg but the following day, she tells her friends that she was attacked in the club and had to go to the hospital to have her leg treated.

5. An 18-year-old student who recently started university finds it hard to talk to others. He would like to make new friends, but finds everything too intimidating. He rationalises that he would not fit in as he comes from another part of the country and thus would have nothing in common. Because he is scared of being rejected by his classmates, rather than attending classes, he spends the majority of the time alone in the library and at home.

Personality disorders II

A. Antisocial
B. Avoidant
C. Borderline
D. Dependent
E. Histrionic
F. Narcissistic
G. Obsessive compulsive
H. Paranoid
I. Schizoid
J. Schizotypal

Select the most appropriate diagnosis from the above that fits with the following clinical descriptions.

1. A 22-year-old male gets angry after finding out that he failed his college examinations, saying that the paper was badly set. He has very few friends as he is very picky and feels some of his peers are not up to his level. His parents aren't too worried, saying that 'he has always been like that.'

2. A 20-year-old female with a history of childhood sexual abuse has chronic suicidal ideation. She is currently in an abusive relationship marked by arguments, but still prefers to be with her boyfriend. She presents to the hospital today for deliberate self-harm, and tells the duty doctor: 'You are the best doctor I have ever come across'.

3. A 29-year-old female, who has always been described as odd and strange by her friends, has a very strong interest in the occult and mystics, and believes that she is able to see spirits. Despite coming from a middle class English family, she prefers to wear traditional Native American clothing as she believes this will help her connect with nature better. She once saw a cat being run over by a car, and decided to become a vegetarian then as she took the incident as being a divine message from God.

4. A 19-year-old male dropped out of school at the age of 13 years for violent behaviour. He has been spending his days doing nothing but pacing around the streets and pick-pocketing from

strangers. He has been convicted several times in the past for armed robbery, and claims that this was done for self-defence. He appears to have no remorse for the victims, and has never been able to maintain a relationship.

5. A 29-year-old waitress has never been able to live alone. Ever since finishing university, she has always lived in an apartment with her friends as she finds the prospect of living alone too daunting. She constantly needs reassurances and support from her friends, and does not appear to be able to make up her own mind about anything. When her friends ask her for a favour, she always complies as she finds it difficult to refuse them.

The patient with unusual eating habits

A. Anorexia nervosa
B. Binge eating disorder
C. Bipolar affective disorder
D. Bulimia nervosa
E. Depression
F. Diabetes mellitus
G. Obsessive-compulsive disorder
H. Paranoid schizophrenia
I. Specific phobia
J. No mental illness

The following patients present with unusual eating patterns. Select the appropriate item from the above that is the most likely underlying diagnosis in the following scenarios.

1. A 21-year-old female has not been eating adequately for the last 6 months and has lost approximately 15 kg in weight. She claims that all food and tap water are contaminated with cyanide and thus has been taking food supplements and bottled water only. On examination, her BMI is 15 and she has not had her menstrual periods for almost 3 months.

2. A 20-year-old male spends the majority of his time at home eating greasy fast food, playing on the computer, and sleeping all day. He does not seem to engage in any physical activities despite constant encouragement from his family, citing that he is 'too lazy'. On examination, his BMI is 34 and abdominal stretch marks are noted.

3. A 28-year-old female is brought to hospital by her family as she has lost a considerable amount of weight in 4 weeks. She describes having no appetite or energy, and has lost interest in looking after herself. This seems to have started following her divorce, and she feels guilty about the break up of her marriage all the time. Her BMI is 19.

4. A 19-year-old female is brought to hospital as she collapsed at work. She reports that she is in the midst of a 'strict dieting regimen' as she feels that she is too fat. For the last 8 months, she

has been eating a small portion of salad a day, working out 5 days a week, and taking appetite suppressants. She has not had a menstrual cycle in 3 months. On examination, she is weak, anaemic, and her BMI is 16.

5. A 21-year-old female is complaining of feeling bad about herself because she feels that everyone around her is looking down on her. As a means of releasing her stress, she goes through periods of frantically eating three boxes of cereals and eight bars of chocolates in one go. Following this, she feels even worse and ends up making herself sick. Her BMI is 25 and her history is significant for polysubstance and alcohol use.

Physical consequences of eating disorders

A. Arrhythmia and cardiomyopathy
B. Cerebral atrophy (pseudoatrophy)
C. Tachycardia and malignant hypertension
D. Hypernatraemia and hyperkalaemia
E. Hypoglycaemia with raised cholesterol and amylase
F. Hypophosphataemia
G. Hypothalamic dysfunction with decreased gonadotrophins
H. Lanugo hair
I. Metabolic acidosis
J. Russell's sign

Select the most appropriate item from the above for each of the following statements.

1. Included in the ICD-10 diagnostic criteria for anorexia.

2. Consequence of excessive laxative use.

3. Leading cause of mortality in patients with anorexia.

4. Indicative of repeated self-induced vomiting.

5. Core feature of refeeding syndrome.

Answers

Psychotic illness I

1. **D.** Hebephrenic schizophrenia is a subtype of schizophrenia that is characterised by changes in affect (flattening or incongruity of affect), thought disorder, and behaviour that is aimless or disjointed. Mannerisms are also quite common. Hallucinations and delusions are usually fragmentary and do not dominate the clinical picture. Individuals tend to become socially isolated and tend to develop prominent negative symptoms. This type of schizophrenia is usually diagnosed in adolescents or young people.

2. **E.** Paranoid schizophrenia is a common subtype of schizophrenia where delusions and hallucinations are prominent. The delusions are not necessarily persecutory in nature, but they all must pertain to the individual, whether it be grandiose, love, etc. Other symptoms such as abnormalities of affect, catatonic symptoms, or thought disorder may be present but not to a significant degree.

3. **I.** Simple schizophrenia is an uncommon and controversial subtype of schizophrenia, which is characterised by at least a 1 year history of progressive development of negative symptoms (apathy, blunting of affect, lack of initiative and drive), gradual changes in social behaviour, and social withdrawal. There is no evidence of preceding acute psychotic symptoms.

4. **A.** Acute and transient psychotic disorder is characterised by the acute onset of psychotic symptoms, usually within 2 weeks. The symptoms resolve within a few weeks and in some cases after a few days. It is best thought of as a 'one-off' psychotic episode.

5. **G.** Schizoaffective disorder comprises symptoms that meet some diagnostic criteria for both an affective disorder (depression, mania, mixed type) and schizophrenia. The symptoms must occur simultaneously and in approximately equal proportions. It does *not* include patients with schizophrenia who go on to develop affective symptoms or patients with an affective disorder who go on to develop psychotic symptoms.

Notes

- For an ICD-10 diagnosis of schizophrenia, one of the following must be fulfilled for at least 1 month:
  - At least *one* of the following must be present: thought insertion, withdrawal, broadcast, echo; voices giving a running commentary or discussing the patient's behaviour; delusional perception; passivity phenomena, delusion of control; persistent delusions. These are mostly Schneider's first-rank symptoms.
  - At least *two* of the following must be present: persistent hallucinations in any modality; formal thought disorder (such as incoherent speech and neologisms); catatonic symptoms; negative symptoms; decrease in social functioning.
- For a DSM-IV diagnosis at least two symptoms (delusions, hallucinations, disorganised speech, negative symptoms, catatonic symptoms) must be present for at least 1 month, including signs of disturbance for at least 6 months.

Psychotic illness II

1. **F.** Residual schizophrenia is a chronic stage in schizophrenic illnesses where there is a clear progression from an active psychotic phase to a chronic negative phase. The negative phase comprises of psychomotor retardation, affective blunting, reduced motivation, reduced speech output, and a decline in social functioning. Both simple and residual schizophrenia are similar in that they are marked by a negative phase, but residual schizophrenia is always preceded by an active psychotic phase while simple schizophrenia does not.

2. **E.** Paranoid schizophrenia is marked by hallucinations and delusions. The delusions are usually paranoid in that they relate to the patient, but it does not necessarily have to be persecutory in nature. In this example, the patient is experiencing delusions of grandiosity with some persecution. Grandiose delusions are commonly seen in bipolar affective disorder, but this has been ruled out in this patient due to lack of manic symptoms.

3. **H.** Schizotypal disorder is classified as a schizophrenic illness in ICD-10, but belongs to personality disorder in DSM-IV. It is thought to be related to schizophrenia in that the incidence is higher in relatives of patients with schizophrenia. It is similar

to schizophrenia but lacks the hallucinations and delusions (although transient psychotic experiences may occur). Characteristics seen are ideas of references, odd beliefs, eccentric appearance and speech, inappropriate affect, suspiciousness, and social anxiety.

4. **B.** Bipolar affective disorder is a mood disorder characterised by the presence of several depressive and manic/hypomanic episodes during the lifetime of a patient. In this example, the patient is exhibiting grandiose delusions with manic symptoms such as pressured speech and flight of ideas.

5. **C.** Catatonic schizophrenia is dominated by psychomotor disturbances, which may fluctuate between extremes of excitement and hyperkinesis to stupor and mutism. Catatonic behaviours such as automatic obedience and posturing are also seen.

Notes

- Undifferentiated schizophrenia is a condition that meets the general diagnostic criteria for schizophrenia, but does not fit with one particular subtype. For example, a patient may exhibit thought withdrawal but have no other behavioural symptoms to specify the type of schizophrenia.

The anxious patient

1. **I.** Social phobia is characterised by a marked fear of being the focus of attention and the fear that one will behave in an embarrassing or humiliating way. This leads to avoidance of social situations such as speaking or eating in public. The individual may present with blushing, shaking, nausea, vomiting, or urgency of micturition during these situations.

2. **B.** Agoraphobia is the fear and avoidance of crowded places, public places (such as shops), travelling alone (e.g. on trains or buses), and being away from home. There are symptoms of anxiety, which are restricted to these 'unsafe' situations only. Agoraphobia may or may not be associated with panic attacks.

3. **F.** Obsessive-compulsive disorder is characterised by recurrent obsessional thoughts and compulsions. Obsessions are recurrent

and unpleasant thoughts, images, or impulses that intrude into the patient's mind and are recognised by the patient as being his or her own thoughts. Compulsions are acts that are repeated constantly and carried out to relieve anxiety or to prevent an event from happening, such as a loved one getting hurt. The patient attempts to resist these obsessions and compulsions, often with limited success, and recognises that they are irrational or absurd. The obsessions and compulsions cause significant social and occupational distress.

4. **G.** Panic disorder is characterised by recurrent panic attacks. An episode of a panic attack develops rapidly and peaks at around 10 minutes, and usually does not last for more than 20–30 minutes. Typical symptoms include palpitations, sweating, trembling, chest pain, shortness of breath, numbness or tingling, fear of losing control, and a fear of dying. It is important to exclude a substance misuse disorder or a medical disorder such as hyperthyroidism, Cushing's syndrome, hypoglycaemia, phaeochromocytoma, anaemia, and cardiac arrhythmias. Comorbidity with other psychiatric disorders is common (agoraphobia, depression, and other anxiety disorders).

5. **E.** Hypochondriasis is the persistent preoccupation of having a serious physical disorder or the preoccupation with a presumed deformity or disfigurement (body dysmorphic disorder). The symptoms cause distress and lead the patient to seek medical treatment or investigations, but there is a refusal to accept reassurance.

Notes

- Generalised anxiety disorder is characterised by generalised, persistent anxiety or excessive worry about daily events and problems, associated with muscle tension, sleep disturbance, and autonomic hyperactivity. This is a chronic disorder lasting longer than 6 months.

- Anxiety disorders can be simplified as follows:
  - Is anxiety generalised or episodic? If general: *generalised anxiety.*
  - If episodic, is the trigger known or random? If random: *panic disorder.*

– If trigger known, specify trigger as:
Simple phobia (objects or situations)
Agoraphobia (unsafe places)
Social phobia (social situations).

The stressful patient

1. **C.** An adjustment disorder must occur within 1 month of a psychosocial stressor and should not occur for longer than 6 months, except in the case of a prolonged depressive reaction, which may last up to 2 years (ICD-10). Symptoms cause significant distress but are not severe enough to meet the criteria of a major psychiatric illness such as depression. A bereavement or grief reaction also fits into this category.

2. **I.** Post-traumatic stress disorder is a severe psychological disturbance that occurs following a traumatic event. Symptoms (ICD-10) include persistent reliving of the incident in the form of flashbacks or nightmares, avoidance of situations resembling or associated with the incident, inability to recall completely or partially some aspects of the event, and persistent symptoms of arousal (difficulty concentrating, irritability, difficulty falling asleep, hypervigilance, and exaggerated startle response).

3. **A.** Abnormal grief reaction is grief that is delayed (by more than 2 weeks), prolonged (greater than 6 months), or abnormal in grief content. Symptoms include feelings of worthlessness, excessive guilt, suicidal ideation, hallucinatory experiences (other than the voice or image of the deceased), and denial. On the other hand, normal grief is characterised by disbelief, numbness, anger, sadness, tearfulness, and pseudohallucinations of the deceased, which eventually resolves by 6 months.

4. **B.** An acute stress reaction is a transient disorder that usually develops within an hour of a stressor and resolves within a few hours or days. Symptoms may include disorientation, feeling 'dazed', aggression, social withdrawal, anger, and despair.

5. **E.** Conversion or dissociative disorders are associated with a loss or disturbance of normal functioning. The symptoms develop in close relationship to a psychological stressor. Symptoms include paralysis, sensory loss, seizures, amnesia, and loss of speech.

The disturbance conforms to the patient's understanding of the disorder and physical examination is often inconsistent with the patient's symptoms. Investigations are normal. Most symptoms resolve after a few weeks or months, but some disorders may become chronic if associated with insoluble or unbearable personal problems. In this vignette, the patient displays dissociative motor disorder.

Notes

- Simple (specific) phobia refers to an intense fear induced by the presence of a specific object or situation, such as heights and spiders.

The patient with unexplained symptoms

1. **D.** In factitious disorder, patients falsify symptoms of medical or psychiatric illnesses for the purpose of receiving medical attention and treatment. The motives for such behaviour are usually unclear. It is also known as Munchausen's syndrome.

2. **G.** Malingering is the falsification of symptoms for secondary gain. This may include attempting to escape a prison sentence, military service, or an attempt to obtain an opiate prescription.

3. **I.** In somatisation disorder, the individual is preoccupied with *physical symptoms* for which no medical cause has been found. It causes significant distress and functional impairment. The patient often has a history of consulting many doctors for an opinion and is not reassured by normal investigation results. Management involves acknowledging the severity of the symptoms and distress, minimising further investigations, ensuring that one doctor co-ordinates future care, and exploration of symptoms in the context of personal and emotional meaning. Cognitive behavioural therapy (CBT) and psychotherapy may be helpful.

4. **F.** In hypochondriasis, the patient is preoccupied with the fear of having a serious *medical illness* such as cancer and is not reassured by negative investigations. The patient constantly seeks medical advice and reassurance. There may be a history of childhood or parental illness or abnormal illness behaviour.

It is distinguished from somatisation disorder where the preoccupation is with symptoms.

5. **A.** Dissociative amnesia is memory loss that exceeds one's forgetfulness, and can be selective. It involves inability to recall part of one's identity or life. It occurs in clear consciousness and short-term memory (retention) is usually normal. It is a subtype of dissociative/conversion disorder. The signs and symptoms do not conform to medical knowledge and are often based on the patient's own understanding.

Notes

- Ganser's syndrome is a dissociative disorder with four central features: psychogenic physical symptoms, approximate answers, pseudohallucinations, and clouding of consciousness. On questioning, patients give inconsistent answers and may present with amnesia for the whole episode.
- Trance and possession disorder is characterised with trance (temporary alteration of the state of consciousness, including loss of personal identity, awareness of surroundings, and limitation of movements) and possession (conviction that the individual has been possessed or taken over by another being). These must be unwanted and occurring outside religious or culturally accepted situations.
- Dysmorphophobia is a condition whereby the individual feels that a part of his or her body is disfigured or out of proportion, and experiences great anxiety and distress as a result of this preoccupation. These beliefs are overvalued ideas or obsessions, but not delusional in intensity. In ICD-10 it is classified under hypochondriacal disorder.

The patient with memory problems

1. **H.** Jamais vu is the experience of a situation being unfamiliar even though it has been experienced before. It can be a normal experience but may also occur in some disorders such as temporal lobe epilepsy and schizophrenia. The opposite of jamais vu is déjà vu, where an experience is perceived as being familiar although objectively it has never been experienced before.

2. **A.** The patient in the scenario is suffering from Korsakoff's syndrome, a recognised complication of chronic alcohol abuse. The prominent feature here is that of anterograde amnesia, which is the inability to form new memories. The converse of this is retrograde amnesia, which is the inability to recall memory before an amnesic episode.

3. **G.** Dissociative fugue is associated with a stressful event and involves the individual undertaking an unexpected but organised journey from home during which self-care is maintained. The patient's behaviour may appear completely normal to passers by. There is partial or complete amnesia for the event.
   - Dissociative amnesia refers to memory loss that may be selective and is a possible choice. However, the vignette describes the patient taking a trip with evidence of adequate self-care, and thus dissociative fugue would be the better answer.

4. **D.** Delusional memory is used to describe either a situation where a patient 'remembers' past experiences that clearly did not occur, or when a normal memory is given a delusional meaning. The vignette described here refers to the first definition, as the patient claims she remembers an event that did not happen.

5. **B.** Confabulation is the falsification of memory occurring in clear consciousness in association with organic amnesia. In these cases, patients fill the conversation with anything that comes to mind in an effort to mask their memory loss and thus the content is heavily influenced by the conversation taking place. Confabulation is often seen in patients with Korsakoff's syndrome.

Notes

- Delusional misidentification refers to patients being unable to correctly identify another person or place correctly, for example claiming that an individual has been replaced by an imposter.
- Malingering refers to the conscious production of false symptoms for clear secondary gain and memory loss may be faked for clear gain, such as an individual trying to avoid a court hearing by claiming to have lost all memory.

Mood disorders I

1. **F.** Dysthymia is characterised by the presence of chronic low mood, which must be present for at least 2 years but not severe enough for a diagnosis of a depressive disorder. There may be intervening periods of normal mood but these do not last longer than a few weeks.

2. **C.** Depressive disorders are classified into mild, moderate, severe without psychotic features, and severe with psychotic features according to ICD-10. The severity of the episode is dependent on the number and intensity of the depressive symptoms, and must be present for at least 2 weeks:
   - *Core* depressive symptoms are low mood, decreased energy, anhedonia.
   - *Associated* symptoms are disturbed sleep, diminished appetite, self-harm impulses, disturbed attention/concentration, feelings of guilt/worthlessness, hopelessness, low self-esteem.

   The following are the diagnostic guidelines for ICD-10:
   - *Mild*: Total of four core and associated (at least two core symptoms).
   - *Moderate*: Six core and associated symptoms (at least two core symptoms).
   - *Severe*: Eight core and associated symptoms (all core symptoms needed).

   A diagnosis of *recurrent depressive disorder* is made when a patient has at least two depressive disorders without any previous history of hypomania or mania.

3. **A.** The vignette described sounds like a mild or moderate depressive episode, but given the patient's previous history of a manic episode, the best diagnosis is bipolar affective disorder, which by definition is characterised by two or more episodes of significant mood disturbance, of which one episode must be hypomania or mania.
   - Bipolar affective disorder is further subdivided into two. Type I is characterised by depressive episodes with at least one *manic episode*, while type II is characterised by depressive episodes with at least one *hypomanic episode* (but not mania).

4. **I.** Mania is an episode characterised by symptoms of elevated mood (for at least 1 week), increased activity, pressure of

speech, flight of ideas, decreased need for sleep, loss of social inhibitions, and reckless behaviour (overspending, reckless driving). There may be mood-congruent psychotic symptoms, which frequently are grandiose delusions and second-person auditory hallucinations.

- Hypomania is a milder form of mania, in which the patient clearly has an elevated mood but the symptoms are not severe enough to cause disruption to social life.
- The vignette described here cannot be bipolar affective disorder because this was the first affective episode for the patient.

5. **E.** The vignette describes an episode of severe depression characterised with psychotic features. Psychotic symptoms are mood congruent and include delusions of guilt, worthlessness, poverty, nihilistic delusions, and second-person auditory hallucinations of voices that are derogatory in nature.

Notes

- Hypermania does not exist.
- Cyclothymia is a persistent instability of mood characterised by mild depression and mild elation, none of which are severe enough to qualify for a formal diagnosis of bipolar affective disorder or recurrent depressive disorder.

Mood disorders II

1. **D.** Depression in the elderly is more likely to present with somatic, anxiety, or hypochondriacal symptoms, nihilistic delusions, delusions of poverty or physical illness, cognitive impairment (pseudodementia), and severe psychomotor agitation or retardation. Pseudodementia is poor concentration and memory associated with depression that can mimic dementia. It usually improves when the symptoms of depression resolve.

2. **H.** Postpartum (puerperal) psychosis occurs in 0.2% of live births. Features include labile mood, perplexity, disorientation, insomnia, psychotic symptoms, and thoughts of suicide or harming the baby. Other risk factors include lack of social support and a personal or family history of postpartum psychosis, bipolar affective disorder, or schizophrenia.

3. **A.** Features of atypical depression include a reactive mood, reversal of diurnal variation in mood (mood better in the morning), increased appetite, weight gain, and increased sleep. Atypical depression is thought to respond better to monoamine oxidase inhibitors.

4. **J.** Seasonal affective disorder is associated with recurrent episodes of depression, which has a seasonal pattern of episodes in winter. Mild hypomania may occur in the summer. Ultraviolet light therapy is associated with a good response.

5. **C.** In young children depression may present as irritability, hyperactivity, tantrums, apathy, poor feeding, somatisation, and regression (enuresis, soiling). In older children features include school refusal, poor performance at school, somatisation, and poor sleep. The prevalence of depression before puberty is roughly equal between the sexes but increases in females after puberty.

Notes

- Postpartum blues ('baby blues') is experienced by up to 75% of mothers and occurs about 2–3 days after birth and lasts for 1–2 days. The mother is typically tearful and emotionally labile, but this is self-limiting and only reassurance is usually required.
- Postpartum depression is a significant depressive episode that occurs in 10–15% of pregnant women, peaking around 3–4 weeks after childbirth. The symptoms are similar to that of any other depressive episode, but usually are related to the baby's health or ability to cope. Risk factors are history of depression, single motherhood, ambivalence towards the pregnancy, and poor social support.
- Bonding failure occurs when the mother fails to develop a normal loving, emotional relationship with her baby, usually in the context of unwanted, ambivalent pregnancies or depressive illness.
- Premenstrual syndrome is a collection of psychological (mood disturbance, insomnia, poor concentration) and physical (headache, bloating) symptoms occurring 24 hours after ovulation, and quickly relieved by menstrual flow.

Personality disorders I

Personality disorders are deeply ingrained and enduring patterns of behaviour, which manifest as inflexible responses to a broad range of personal and social situations, and are a significant deviation from how the average person in a given culture thinks, feels, and relates to others. They are frequently associated with subjective distress and problems in social functioning.

1. **J.** Schizoid personality disorder is characterised by emotional coldness and detachment, preference for solitary activities, excessive introspection, no desire for relationships, indifference to either praise or criticism, and a marked insensitivity to social norms and conventions (but this is unintentional). These patients are 'loners' who prefer their own company.

2. **A.** Anankastic (or obsessive) personality is characterised by excessive concern with details and order, excessive conscientiousness, perfectionism that interferes with task completion, feelings of excessive doubt and caution, rigidity and stubbornness, and insistence that others submit to his or her way of doing things.

3. **F.** Emotionally unstable personality disorder has two subtypes. The impulsive subtype is associated with a tendency to act unexpectedly without consideration of the consequences, quarrelsome behaviour, outbursts of anger or violence, and an inability to control such behavioural explosions. Unstable mood and difficulty in maintaining a course of action that offers no immediate reward are also seen.

4. **G.** Histrionic personality disorder is characterised by a shallow and labile affect, over dramatisation or exaggerated expression of emotions, suggestibility (easily influenced by others), over concern with physical appearance, inappropriate seductiveness in appearance and behaviour, and the need to be the centre of attention.

5. **B.** Anxious personality disorder is characterised by persistent feelings of tension and apprehension, the belief that one is socially inferior, and excessive preoccupation with being criticised or rejected. This leads to avoidance of social and

occupational activities and unwillingness to engage with people unless certain of being liked. Unlike those with schizoid personality disorder, these patients want social interaction but are unable to do so.

Notes

- The types of personality disorders differ slightly between ICD-10 and DSM-IV, and those listed in this question derive from ICD-10. Dissocial personality disorder is known as antisocial in DSM-IV, and emotionally unstable impulsive type does not exist in DSM-IV.
- Passive aggressive is also known as negativistic personality disorder and characterised by passive resistance to authoritarian circumstances, manifesting as procrastination, stubbornness, resentment, and forgetfulness. For example, a person who is opposed to a specific project may frequently miss meetings or make errors as a means of protest.

Personality disorders II

1. **F.** Narcissistic personality disorder includes a grandiose sense of self-importance, preoccupation with fantasies of unlimited success, the belief that he/she is special and should only associate with other special or high-status people, a sense of entitlement, the need for excessive admiration, a lack of empathy, and envy towards others or believes that others are envious of him/her.

2. **C.** Borderline personality disorder is characterised by disturbances in self-image and/or internal preferences (such as sexuality), intense and unstable relationships, self-harming, excessive efforts to avoid abandonment, and chronic feelings of emptiness. A fairly significant proportion of deliberate self-harmers presenting to hospital fall into this category.

3. **J.** Schizotypal disorder is classified as a personality disorder in DSM-IV but not in ICD-10 (schizophrenic spectrum disorder). Features include eccentric appearance or behaviour, cold and aloof affect, odd beliefs and magical thinking that is inconsistent with social norms, paranoid ideas, unusual perceptual experiences, and transient quasi-psychotic episodes.

4. **A.** Antisocial personality disorder is characterised by irresponsibility and disregard for social norms and rules, callous disregard for the feelings of others, tendency to become aggressive, inability to experience guilt, inability to learn from punishment, tendency to blame others, and an inability to maintain relationships.

5. **D.** Dependent personality disorder is characterised by the need of encouragement from others to make important decisions, inability to make everyday decisions without the need for excessive reassurance and advice from others, feelings of helplessness when left alone, undue compliance with the wishes of others, and an unwillingness to make even reasonable demands on the people one depends on.

Notes

- The choices in this question derive from the DSM-IV classification of personality disorders, which differ slightly from ICD-10. Passive-aggressive disorder was recognised as a personality disorder in the old DSM-III, but was omitted in DSM-IV and put in the appendix as there were controversies regarding its use.
- Paranoid personality is marked by a strong sense of suspiciousness, sensitivity to setbacks, tendency to bear grudges, and an unwillingness to forgive. Other features include a high sense of entitlement to personal rights, persistent self-referential attitudes, and a tendency to distort experiences as being hostile or threatening.

The patient with unusual eating habits

1. **H.** The patient in this vignette has decreased food intake associated with decreased weight and physical abnormalities, which all stems from her delusional beliefs regarding poisoned food and water. The presence of this delusion therefore suggests a diagnosis of schizophrenia.

2. **J.** The patient in this vignette is obese due to his BMI of 34 (obesity defined as BMI >30), but the underlying cause of this obesity is his unhealthy eating habits and physical inactivity. There is thus no evidence of a mental illness, but treatments should be mainly behavioural and psychological to re-establish sensible eating and physical activity.

3. **E.** Depression is the underlying cause of this patient's decreased appetite, as evidenced by her anergia, anhedonia, and constant sense of guilt.

4. **A.** The ICD-10 diagnostic criteria for anorexia nervosa are BMI of less than 17.5 (or body weight at least 15% less than expected), self-induced weight loss (such as avoidance of fattening foods), self-perception of being fat with fear of obesity, and endocrine dysfunction (such as amenorrhoea in women and impotence in males). The patient in this vignette fulfils these criteria and thus anorexia is the likely diagnosis.

5. **D.** The ICD-10 diagnostic criteria for bulimia nervosa are recurrent episodes of binge eating, persistent preoccupation with eating (craving), attempts to counteract the fattening effects of food through the use of compensatory mechanisms (such as self-induced vomiting, purging, use of appetite suppressants, excessive exercise), and the perception of being too fat with an intrusive dread of fatness. The usual age of onset is later than anorexia, and is usually in the region of late teens to 30 years old.

Notes

- Binge eating disorder is similar to bulimia nervosa, but is not associated with the compensatory vomiting or purging efforts.
- When assessing patients with low weight, it is always important to rule out an organic cause such as diabetes mellitus, malabsorption syndromes, and endocrine diseases (including Addisons and thyroid disorders).
- Poor prognostic factors for anorexia nervosa include longer illness duration, older age of onset, being male, poor parental relationship, and excessive weight loss. Anorexia nervosa usually has an onset around 13–20 years old, and has a male to female ratio of 1:10–20. It is seen more commonly in social classes I and II in industrialised countries, and is more frequent in specific occupations such as models and dancers.
- Efforts to lose weight are seen both in anorexia and bulimia, and vomiting is seen in both conditions.

- Treatment for both eating disorders are education, pharmacological (selective serotonin reuptake inhibitors such as fluoxetine), and psychological (CBT and family therapy). The UK NICE guidelines for anorexia recommend hospital treatment if one of the following criteria are met: BMI <13.5, severe electrolyte imbalance, cardiac complications, severe suicide risk, and failure of outpatient treatment.

Physical consequences of eating disorders

1. **G.** Endocrine complications resulting from disruption of the hypothalamic–pituitary–adrenal (HPA) axis is one of the diagnostic criteria for anorexia nervosa, and this commonly manifest as amenorrhea. Other endocrine disturbances seen in anorexia are raised growth hormone and cortisol levels.

2. **I.** Metabolic acidosis with hypokalaemia is seen with excessive use of laxatives, as bicarbonate and fluid are lost from the gut. There is also evidence that excessive laxative use can lead to renal tubular acidosis. On the other hand, metabolic alkalosis is seen with frequent vomiting, as hydrochloric acid is lost from the stomach.

3. **A.** Cardiovascular complications of anorexia nervosa account for 10% of mortality, and these include significant bradycardia, hypotension (systolic BP less than 70), arrhythmias, ECG changes (QT prolongation may occasionally lead to sudden death), and cardiomyopathies (also prolapsed mitral valve and decreased left ventricular mass).

4. **J.** Russell's sign refers to callused skin on the backs of hands (over the knuckles) due to repeated manual induction of vomiting. Other signs of repeated self-induced vomiting are parotid gland enlargement, eroded tooth enamel, and oesophageal tears.

5. **F.** Refeeding syndrome occurs when a previously starved or severely malnourished patient is recommenced on a normal diet. Upon being refed, carbohydrate metabolism and insulin secretion occur, leading to cellular uptake of phosphate. The resulting hypophosphataemia generally triggers non-specific symptoms, but these can lead to rhabdomyolysis, leucocyte dysfunction, respiratory failure, arrhythmias, coma, seizures,

and sometimes death. This phenomenon usually occurs within 4 days of refeeding and thus regular monitoring of kidney function and electrolytes is necessary. Treatment involves dietician input and supplementation with phosphate.

Notes

- Other physical consequences of anorexia nervosa are:
  - *Gastrointestinal*: Delayed gastric emptying, gastric atrophy, constipation.
  - *Metabolic*: Hypokalaemia, hyponatraemia, hypoglycaemia, hypocalcaemia, hypomagnesaemia, hypercholesterolaemia, deranged thyroid function.
  - *Haematological*: Anaemia, leucopaenia, thrombocytopaenia.
  - *Neurological*: Peripheral neuropathy, cerebral pseudoatrophy, ventricular enlargement.
  - *Physical signs*: Lanugo (thin, fine) body hair, brittle nails, hypothermia.
  - *Musculoskeletal*: Osteoporosis, proximal myopathy.